NC DMA Carolina ACCESS Referral Form

Recipient Information

DMA-0009

Recipient ID #: _____

Last Name: _____ First Name:_____

Date of Birth: _____ Gender: _____

Referring Provider Information

Referring Provider's NPI #:_____

Referring Provider's Name of Practice: _____

Site Address: _____

City: _____ State: _____ 9 Digit Zip Code: _____

Referred to Provider Information

8. Referred to Provider's NPI #: _____

9. Referred to Provider Name of Practice: _____

Site Address: _____

City: _____ State: _____ 9 Digit Zip Code: _____

Referral Information

10. Referral Type: ☐ Evaluate ☐ Treat ☐ Evaluate and Treat

11. Referral Start Date: _____

12. Referral End Date: _____

13. Number of visits: _____ ☐ Unlimited visits (unlimited visits with no end date)

A Referral does not guarantee payment. Payment of claims is subject to compliance with DHHS guidelines and restrictions

Complete this form to request a Carolina ACCESS referral be processed by CSC. Instructions for completing this form can be found at ***http://www.NCTracks.com/Referralformhelp***

Requestor's Name _____ Phone Number: _____Ext_____

Referring Provider's Signature:_____ Date:_____

Fax this form to CSC at: (855) 710-1964